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ABSTRACT

The report discusses public policy issues affecting services to the disabled. Aspects covered include umbrella versus categorical service organization, independent living, independent living services, deinstitutionalization and the unions, utilizing Medicaid for 24 hour residential services, national health insurance, financing home services and attendant care, federalized health care coverage for Social Security Insurance and Disability Insurance recipients, a federal long term care program proposal, changing existing federal matching rates, the future of congregate housing, housing construction, housing rehabilitation, housing lease and purchase, providing "related services" under education for handicapped children mandates, the future role of sheltered workshops and work activity centers, the expansion of civil rights, 1981 developmental disabilities legislation, and promoting a normalizing lifestyle. (Author/DLS)

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PUBLIC POLICY ISSUES AFFECTING SERVICES TO PERSONS WITH DISABILITIES: A 1980 PERSPECTIVE

This paper was developed for the Workshop for Nonprofit Agency Professionals hosted by the Granite State United Cerebral Palsy Association, Inc., Manchester, New Hampshire

BY

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February, 1980

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INTRODUCTION

Before discussing specific public policy issues affecting persons with disabilities, it is important to place these issues in the perspective of the federal domestic climate as we enter the 1980's.

Federal aid as a per cent of a state-local expenditures has declined from a peak of 26.7% in 1978 to 25.4% in 1979 to an expected 23.6% in 1980. Though most of the national publicity has focused on the tax reduction-service reduction measures, such as California's Proposition 13, similar measures have been defeated in other states. Most of the 13 state measures which have passed are of the tax-spending restraint type which do not reduce services. For the next several years one can anticipate governmental funding to remain generally constant. Overall, this means little new initiatives and few substantial reductions.

During the 1970's a tremendous growth occured in the federal "generic" service programs, e.g., Medicaid, Medicare, Supplemental Security Income. Once a person becomes eligible for these services, the open ended budgets they operate under results in stable and ongoing support for the individual as long as they are eligible. The application of a "means-test," which means a person has income below some arbitrary level, is the major characteristic of most generic service programs. Thus, one can anticipate improved and more liberalized benefits for low income disabled persons under federal generic programs.

Growth is also anticipated in the federal "entitlement" programs such as the P.L. 94-142 "Education For All Handicapped Children Program." It is not anticipated that Congress will go back on its commitment under P.L. 94-142 although this law may be used as an excuse to reduce benefits to disabled persons under other federal education programs such as the Title I Elementary and Secondary Education Act program for disadvantaged children. A major conflict in the early 1980's will be to continue the momentum under P.L. 94-142 while simultaneously protecting benefits for the disabled under other education programs.

The overall slow growth in federal expenditures with anticipated growth in the generic and entitlement programs will probably result in substantial budget restraint for "categorical" programs such as vocational rehabilitation, independent living, and services to the developmentally disabled.

Of course, all of these predictions, based upon trends of the last several years, can change overnight given events influencing the national economy, our social conscience, the sophisication and activism of the disabled community, and the political environment.

The public policy issues discussed in this paper are in no particular order. They are randomly ordered without a consistent theme; they are a consistent reflection of UCPA's public policy priorities for 1979-1980.

UMBRELLA VS CATEGORICAL SERVICE ORGANIZATION

Public administrators have been debating for a decade the classic argument of whether publicly financed human services should be organized and administered through categorical or umbrella agencies. Conventional public administration "wisdom" argues that consolidated or umbrella agencies are efficient and effective units of government. From the advocate's perspective, the fundamental issue involves targeting of resources. As the Human Resources Organization Studies Group of the President's Reorganization Project concluded:

> "The primary disadvantage of program consolidation is that some desirable targeting of resources on very specific needs and problems may be lost" (President's Reorganization Project, July, 1978).

Experience has repeatedly demonstrated that low visability groups, such as the disabled and subgroups within the disabled, tend to lose resources unless a specific target to their needs exist. This is the fundamental assumption; umbrella agency proposals do not guarantee a continuation of targeting.

There is a trend toward what some refer to as "the cybernetic state" which has a systemic rather than a functional orientation. Such a system tends to be guided by systems engineers, planners, and other generalists whose perspectives presumably transcend their functional specialities. The emphasis in such a system is on "central-guidance clusters," such as the Council of Economic Advisers and the Office of Management and Budget. In theory, mass, class, and individual identities become more important than group associations. Those representing target populations do not feel confident that these system engineers have the understanding, awareness, or sensitivity to adequately plan services for specific target groups. Functionalism may not be as efficient as a systems approach but it is probably more representative. The major reservation about an integrated human service delivery system is that the unique objectives of low visability interest groups within society may tend to receive short shrift in organizational configurations emphasizing efficiency.

What has been the experience of persons with disabilities with umbrella agencies? Several years ago the state of Florida consolidated its Vocational Rehabilitation (VR) program into an umbrella human service agency. A federal audit of the performance of the umbrella agency's rehabilitation of handicapped persons confirms the advocate assumption. Between 1973 when the Florida VR agency operated as a single state agency categorical program and 1977 after several years umbrella experience, the total number of handicapped people served declined 52%. The auditors concluded that "there is evidence that considerable amounts of VR money also are being diverted" resulting in a suspension of services to 4,154 disabled persons in 1978. As a result of the audit, Florida may have to repay the federal government $2.2 million in federal VR funds which was misspent on other services. The Florida example demonstrates that handicapped people are not better served by umbrella agencies and that their needs are better respected by categorical programs.

The June, 1978 Human Resources Organization study contains an excellent statement of the central dilemma: "The desire for a flexible, pluralistic system of service agencies responding to specific client and community needs is difficult to reconcile if not in conflict with the preference for a coordinated and comprehensive service delivery system which can be administered according to a consistent set of goals and by administrative mechanisms broad enough to address the many needs of individuals and families."

The debate between categorical and umbrella agency responsibility will continue for years. It will generally be resolved through political considerations. Advocates for persons with disabilities will generally maintain the necessity for a categorical approach.

INDEPENDENT LIVING: A SERVICE, A FUNDING PROGRAM, OR A SOCIAL MOVEMENT?

UCPA affiliates have long been dissatisfied with Vocational Rehabilitation's failure to serve persons with severe handicaps, have developed special support programs for persons excluded from generic service systems because of the severity of their disability, and have advocated for a permanent funding base to finance supportive services which will allow severely disabled persons to live in the community. This advocacy has been an objective of the UCPA Washington Office since its establishment in the fall of 1968. The P.L. 95-602 Title VII Comprehensive Services For Independent Living Program is a response to this advocacy effort.

The IL program is also a response to a new social movement, the movement for independent living. In describing the IL movement, Gerben DeJong focuses on the Center for Independent Living at Berkeley, organized in 1972, and the American Coalition Of Citizens With Disabilities, organized in 1974, as the "real beginnings" of the movement. DeJong views IL as a consumer movement and a social phenomenon characterized by the following philosophies:

- Consumerism: "Basic to consumerism is a distrust of seller or service provider...With the rise of consumer sovereignty, professional dominance in disability policy and rehabilitation is being challenged."

- Self-Help: The objective of the "self-help movement" is to "give people the opportunity to exercise control over their own lives and the services they use." This movement is fueled by the same "distrust of professionally dominated services" as consumerism. These proponents view themselves as "an alternative service provider" emphasizing peer counseling and advocacy services which, according to DeJong, are "not provided by mainline human service organizations."

- Demedicalization: This concept supplements self-help and consumerism by challenging the dominance of medical professionals and furthering self care. It maintains that individuals can and should take greater responsibility for their own health and medical care. To DeJong, once medical stability of a disability has been obtained, "medical presence is both unnecessary and counterproductive... Disabled persons are insisting that the management of their disabilities is primarily a personal matter and only secondarily a medical matter."

DeJong maintains that the IL movement has concentrated its energies on a relatively few major disability groups - those with spinal cord injury, muscular dystrophy, cerebral palsy, multiple sclerosis, and post-polio disablement - and on the older adolescent and younger working age adult. This age focus is a function of the disability conditions emphasized to-date and the communities (large academie settings) where IL has taken root.

Consumer sovereignty and self reliance have combined into a movement concerned primarily with civil, political, and economic/benefit rights.

Six specific services have become closely associated with the IL movement:

- Advocacy services to acquire rights and entitlement;
- Peer Counseling to "foster more assertive behavior in an unaccommodating social and economic environment;"
- Attendant Care services to assist in activities of daily living;
- Removal of architectural barriers;
- Adapted housing; and
- Adapted transportation.

To DeJong, "the movement's philosophy not only affects what services are to be provided but also how services are to be provided."

INDEPENDENT LIVING SERVICES: COMPREHENSIVE SERVICE DELIVERY OR INDIVIDUAL CENTERS FOCUS?

In enacting the P.L. 95-602 Title VII program, Congress authorized in fiscal year 1980 $150 million for the state grant, independent living centers, and services to older blind individuals program. Additionally, $7.5 million was authorized for the protection and advocacy program. The Senate report authorizing the IL program declared the objective of Title VII to be "to build State services and service systems to increase the number of and improve the quality of services for severely handicapped individuals and to assist the States in developing and implementing comprehensive services for all severely handicapped persons." P.L. 95-602 envisioned a substantial new service program with, as the Senate report declares, "sufficient funds" available to develop "effective long-range plans and services."

The Congress appropriated $2 million in f.y. 1979 and the Rehabilitation Services Administration restricted these funds to the Part B centers program. In f.y. 1980, $15 million was appropriated; however, the existing centers for independent living in California successfully convinced Representative George Miller (CA) to offer an amendment, which was accepted, also restricting these funds to the Part B centers program. The President's f.y. 1981 budget requested $18 million for "project grants."

Only through the development of a statewide comprehensive service system will the potential of the IL program live-up to meeting the needs of the severely handicapped. And yet political and fiscal desires have joined limiting the program to project sites.

DEINSTITUTIONALIZATION AND THE UNIONS

Section 133 (b) (29) of P.L. 94-103, the 1975 DD Amendments, mandates the States to provide for fair and equitable arrangements to protect the interests of employees affected by deinstitutionalization. This amendment was strongly advocated by the American Federation Of State, County, And Municipal Employees (AFSCME). At the time many advocates feared that Section 133 (b) (29) could become a substantial obstacle to reducing the size of state institution populations and promoting small, dispersed, community-based facilities.

On June 15, 1979 AFSCME filed a formal complaint against the State of Rhode Island and HEW's Developmental Disabilities Office charging inadequate job protection for employees affected by the state's deinstitutionalization plan. Because the complaint was signed by AFSCME International President Jerry Wurf, such a complaint could be filed in other states. The complaint was filed on behalf of 750 employees (75% of the staff) at the Joseph R. Ladd School.

HEW guideline specify that the states must:

1) Ensure "the preservation of rights, privileges, and benefits (including continuation of pension rights and benefits) under existing collective bargaining agreements;"

2) Ensure "the protection of individual employees against a worsening of their positions with respect to their employment"; and

3) Ensure "maximum efforts be made to guarantee employment of employees..."

AFSCME charges that Rhode Island failed to give AFSCME six months written notice prior to the formation of its deinstitutionalization plan, did not develop its plan in consultation with employee representatives, and did not develop specific employee assurances relating to deinstitutionalization activities. Rhode Island has planned to retrain institutional employees and transfer them to newly established community residences. AFSCME maintains that if these failures are not corrected, HEW must withhold DD funds from Rhode Island.

UTILIZING MEDICAID FOR 24 HOUR RESIDENTIAL SERVICES

- Overview

Since 1971 the legal authority has existed for Medicaid to finance Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and persons with "related conditions" defined as persons with developmental disabilities. Because there is currently no federal ceiling on Medicaid funding, because the

federal matching is very reasonable, and because of severe funding limitations within all federally financed service programs, several states have financed small group residences for the developmentally disabled as ICF/MRs.

For example, in Minnesota there are 20 group homes for the mentally retarded for 6 to 10 persons financed as ICF/MRs. The population served in these community-based facilities is similar to those people who remain in the state institutions. Additionally, 250 private community-based programs for the mentally retarded are certified as Medicaid facilities.

There have been reservations expressed by program staff associated with consumer organizations, such as the Association for Retarded Citizens and UCPA, about the desirability of promoting on a large scale group living arrangements financed completely through the ICF/MR authority. The 1979 annual conference of the National Association of Private Residential Facilities for the Mentally Retarded provided a forum for a debate of this issue.

- Advantages

Those that advocate ICF/MR utilization expansion emphasize several points. One, Medicaid appears to be the most easily available funding resource for residential programs. Two, the states are permitted much flexibility in interpreting Medicaid regulations. Three, the ICF/MR program need not perpetuate the medical model. For example, the requirements for "qualified mental retardation professionals" include backgrounds in the social sciences and education and not necessarily medical or nursing experience.

- Disadvantages

Those who express reservations about promoting ICF/MR funding (no one is totally opposed to developing ICF/MRs for certain persons) emphasize other points of view. One, they maintain that there exists a medical orientation in the ICF/MR program; the authority is contained in the Title XIX "medical services" program. They raise questions such as: Does it maximize independent development? Is programmatic appropriateness determined by funding convenience? Do all residents of ICF/MRs require 24 hour supervision? Two, keeping the Title XX precedent in mind, there is a possibility for Congress to place an abritrary ceiling on Medicaid's open-endedness. The current Congressional concern with cost-containment reflects this concern. Three, many feel that there are added costs attached to ICF/MR construction. Is it not difficult to avoid an institutional orientation because of licensing and fire safety requirements? It generally takes 2 years to develop and construct an ICF/MR; when compared to utilization of existing housing, should deinstitutionalization be held up this long?

Four, the flexibility granted to the states can be a real problem. In Colorado, anyone admitted to a Title XIX facility is required to remain there for a minimum of one year. Five, there is a tendency in ICF/MRs to associate individuals by commonality of classification whether by diagnosis or function; is this normative? Six, does the federal government have the ability to do a good job of monitoring?

And last, there is the possibility of Congressional restrictions on the use of Medicaid for small group residences, particularly non-medical ones. Under existing law, State Medicaid agencies decide if ICF's are qualified to

participate in Title XIX. S. 505 would establish a uniform health care facility certification process for Medicaid and Medicare long-term care facilities. State agencies would continue to survey facilities but HEW would determine a facility's eligibility.

This debate revolves around the honesty of planners, administrators, advocates, consumers, and policy makers in balancing programmatic philosophy and objectives with funding availability. Good intentions and basic value orientations are fundamental to the debate.

THE PANACEA OF NATIONAL HEALTH INSURANCE

For years persons working in the disability field have maintained that all our financing problems will be solved when we enact national health insurance. We have waited a long time and we will continue to wait.

The current emphasis within the Congress is on a catastrophic illness protection schema. S. 350, by Senators Russell Long (LA), Abraham Ribicoff (CT), and Herman Talmadge (GA) and six others, would establish a catastrophic health insurance plan, standardize and federalize the Medicaid program and promote standardization of private health insurance plans. The thrust of S. 350's catastrophic protection is to cover financial burdens for traditional medical services after an individual has incurred a medical bill of $2,000 or spent 60 days in a hospital during a calendar year. Other similar bills are S. 351 and S. 760.

One Repurblcan alternative to S. 350 is S. 748, by Senators Robert Dole (KS), Peter Domenici (NM), and John Danforth (MO), which would expand the range of Medicare benefits and numbers of recipients including the addition of catastrophic coverage, require employers to offer a catastrophic health insurance plan to full-time workers, and authorize the federal government to negotiate between insurance companies and uninsured persons in contracting for catastrophic coverage. Yet another Republican alternative is S. 1590, sponsored by Senator Richard Schweiker (PA) and seven other U.S. Republican Senators. This bill combines features of the other proposals.

The Senate Finance Committee has completed some preliminary consideration of a catastrophic plan. These proposals do not provide a new health insurance program of basic benefits for the disabled. In each proposal existing Medicare and Medicaid benefits continue to be the basic program for the disabled. Catastrophic proposals are acute illness/medical services/hospitalization oriented.

- Chronic Disabilities And Severe Handicaps Under National Health Insurance: An Idealistic Approach

In March, 1978, several voluntary health agencies (e.g., UCPA, Easter Seal Society, EFA) associated with the National Health Council wrote Dr. James J. Mongan, Deputy Assistant Secretary for Health for National Health Insurance, expressing concern that the specialized needs of persons with chronic disabilities and severe handicaps be considered by national health insurance planners. The letter argued that future federal financing mechanisms must take into account the varied medical, rehabilitative, and supportive services necessary to assist these persons. Such financing mechanisms should:

- Provide for financing of medical and health related services outside hospital settings without the requirement of prior hospitalization. This recognizes

that the Medicare "spell-of-illness" concept is fundamentally inappropriate for the chronically disabled and handicapped population.

- Provide for long-term financing of medical care, including rehabilitative care, habilitative care and health related supportive services and equipment for persons who are disabled or chronically ill on both an inpatient and outpatient basis including organized outpatient care as well as home-based care.

- Provide for an organized system of delivering comprehensive habilitative or rehabilitative care to disabled or chronically ill individuals assuring a continuum of services between those health care institutions necessary and the home.

- Provide for a continuum of services between different service delivery systems. For example, the "Education for All Handicapped Children Act" (P.L. 94-142) clearly differentiates between "special education," "related services," and "medical and other health services."

- Provide for comprehensive maternal and infant care services without deductibles or co-payments to increase the likelihood of identifying and treating special conditions as early as possible, thus minimizing or eliminating altogether costs to the health and social service systems in the future.

- Provide for the financing of a system of outreach, in alliance with established national voluntary organizations, to guarantee that disabled and chronically ill individuals are informed and encouraged to take advantage of available health services.

- Provide standards to eliminate discrimination in some private health insurance plans against particular disability categories.

The Carter Administration's National Health Plan was submitted to the Congress on September 25, 1979 (H.R. 5400 and S. 1812). The plan includes three principal components. One, an employer guaranteed coverage to all full-time employees for major medical expenses. Employees would pay no more than $2,500 per year in out-of-pocket payments; i.e., catastrophic coverage. Two, a new Health Care Program which would consolidate Medicare and Medicaid for all low income, including the disabled, persons. Acute care services would no longer be included in state Medicaid plans. States would continue to provide skilled nursing facility and intermediate care services and "optional" services for low income persons under Medicaid. Most decisions affecting the chronically disabled were postponed until an Administration long term care policy could be developed. Three, competition and reform in health care delivery are proposed (e.g., limit hospital capital spending, equal employer contribution to a variety of insurance plans, HMO options).

- Modifying Catastrophic Approaches In Recognition Of Disability

The catastrophic health insurance programs sponsored to-date are based on the very narrow acute-illness benefits currently associated with Medicare. In June, 1979, the Cystic Fibrosis Foundation developed a "Position Paper On National Health Insurance For Catastrophic Expenses" to give people with chronic diseases benefits appropriate to their needs within the framework of catastrophic insurance. Such an approach could be expanded upon for chronic disabilities. The CFF proposal is based on several principles:

- "A National Health Insurance program must begin with the simple premise that no family or individual should face financial ruin in order to obtain adequate medical care."
- All people must be eligible for coverage in the program, regardless of health or employment status.
- All medical expenses must be counted toward the deductible and in the reimbursement formulas.
- The reimbursement formula must take appropriate account of the near poor and those with chronic diseases (and disabilities).

The CFF proposes the following provisions:

- Insurance coverage should be available to all without regard to pre-existing conditions.
- The costs of prescription drugs should be covered under any catastrophic proposal. This concept could be broadened to include other unique costs associated with disability.
- An income-based deductible for out-of-picket expenses should be established (rather than an arbitrary dollar ceiling). A percentage limit (10-15%) would replace the dollar limit for out-of-pocket health care expenses.

Eligibility under the catastrophic approach depends upon meeting a deductible. In addition to how the deductible is determined, the accounting period for the deductible is critical. Since the disabled may have their substantial costs spread over a longer period than someone with an acute illness, a longer accounting period helps. Obviously, the lower the deductible, the less this may be a problem since the low deductible would be met more easily. Modifying the catastrophic approach will be an agenda item for the 96th Congress, 2nd session advocate groups.

FINANCING HOME SERVICES AND ATTENDANT CARE

- Title XX Social Services

The Title XX Social Services Program has been successfully tapped by UCPA affiliates in providing home services and attendant care support of housing opportunities. Some examples include:

(1) UCPA of New York State provides "homemaker services" for residents of their community living arrangements programs;

(2) UCP of Kansas provides "physical support services" for residents of their community living arrangements program;

(3) UCP of Cleveland, Ohio operates an "ambulatory home care" program;

(4) UCP of San Antonio, Texas sponsors a supervised apartment program utilizing "live-in homemakers;" and

(5) UCPA of Pittsburgh, Pennsylvania conducts a life skills management program in conjunction with their supervised apartment program.

- Medicare Limitations

Medicare is by far the largest third-party payor of home health services yet the program contains numerous restrictions on home health care which effectively excludes a large proportion of developmentally disabled persons, particularly those requiring home based services. These limitations include:

(1) Three-day prior hospitalization requirement;

(2) Benefit period requirement whereby services can only be offered within one year of a hospital or skilled nursing facility stay;

(3) Condition-related requirement whereby home health services can only be offered for the same condition for which the person was hospitalized;

(4) Physician plan of treatment requirement whereby home health services can only be authorized by a physician;

(5) One hundred visits during a year limitation; and

(6) One hundred hour limit on personal care per month.

- Medicaid Limitations

Most severely disabled persons are eligible for Medicaid by reason of their receipt of Supplemental Security Income and yet they remain ineligible for home health services because of the way Medicaid benefits are structured federally.

Medicaid regulations require that in order to qualify for home health services an individual must demonstrate a need for skilled medical care. Yet many persons with developmental disabilities do not need this advanced level of care in order to have their physical requirements appropriately met. The services of a home health aide, for example, might be sufficient for them to function optimally in a home environment. Under current restrictions, however, they would be barred from receiving home health care.

The great disparity among states in the types of home services provided under Title XIX creates considerable problems in attempting to monitor the quality of care on a nationwide basis. The problem is compounded by the fact that state licensure requirements for home health agencies vary widely, and as HEW has not

yet required home health agencies to acceed to certificate of need regulations (whereby they would have to demonstrate the need for and quality of services provided in order to come into being or expand), there exist virtually no mechanisms for insuring the quality of services.

- UCPA/ARC Legislative Suggestions

UCPA and ARC presented a joint statement to the Senate Committee on Finance Subcommittee on Health on home health benefits on June 4, 1979. The testimony advocated the following positions:

(1) The federal government should make a national commitment to financing the promotion, development, organization, and delivery of home health services including specific recognition of the needs of the developmentally disabled as a primary target population.

(2) The federal government should facilitate, in full partnership with all appropriate national interests, the development of a set of principles for home health services. Such a statement of principles should recognize the specific health care needs and home service needs of the severely disabled.

(3) Home health benefits under Medicare and Medicaid should be broadened into a rational and effective national financing approach in order for developmentally disabled persons to receive needed and appropriate services. Such benefit changes should include.

(a) Remove the requirement that home health care be predicated on the need for prior hospitalization, skilled nursing, occupational therapy, or physical therapy;

(b) Limit allowances for home health care realistically in terms of hours of care provided rather than the number of visits allowed, thus permitting some daily care;

(c) Specifically provide for coverage of personal care, including attendant care, subject to appropriate prescription and supervision in both Medicare and Medicaid;

(d) Specifically allow coverage of occupational, physical, and speech therapy as qualifying services for home health services, subject to appropriate prescription and supervision in both Medicare and Medicaid;

(e) Recognize non-profit community agencies which provide specialized services to narrowly defined populations (rather than global home health agencies which must provide comprehensive services to all persons) as Medicare/Medicaid home health service providers; and

(f) Develop nationally recognized standards to insure service quality and appropriateness of care. Such standards, developed in full partnership with all appropriate national interests, should recognize the specific health care needs of persons with developmental disabilities.

• Prospects For Congressional Action

On November 5, 1979 the House Committee on Ways and Means reported H.R. 3990, the "Medicare Amendments of 1979." The bill has been referred to the Committee on Interstate and Foreign Commerce which must report it prior to floor consideration.

H.R. 3990 would liberalize the Medicare home health benefit by: (a) allowing unlimited visits under both parts A and B, (b) eliminating the part B $60 deductible, (c) eliminating the present three-day hospitalization requirement under part A, (d) allowing occupational therapy as a home health benefit, and (e) liberalizing the eligibility of properietary home health agencies as providers. The bill would also require home health aides to meet certain qualification standards.

After five months of inaction, in mid-December, 1979 the Senate Finance Committee, in a surprise action, ordered reported H.R. 934, the Medicare-Medicaid reimbursement reform bill. This bill is intended to reduce health care expenditures; however, the Committee added the provisions of Senator Robert Packwood's (OR) bill, S. 1977, the "Medicare Home Health Amendments." The 100-visit limit on home health services would be eliminated and homemaker services, where not available under Title XX, would be allowed.

In the President's F.Y. 1981 budget recommendations, the Administration favors the elimination of the need for skilled nursing care as a prerequisite for home health services under Medicaid; it is anticipated that this proposal will increase Medicaid expenditures by $15 million. The budget also contemplates the elimination of coinsurance and the 3 day prior hospitalization requirement for home health benefits under Medicare with an anticipated expenditure of $194 million. The home health services demonstration program operated by the Health Services Administration ($6 million in 1979 and $5 million in 1980) is eliminated in 1981 because of these proposed Medicaid and Medicare amendments.

FEDERALIZED HEALTH CARE COVERAGE FOR SSI AND DI RECIPIENTS: AN ADVOCATE'S PROPOSAL

In March, 1979, governmental relations staff of the Association for Retarded Citizens and the Paralyzed Veterans of America drafted a proposal to extend reliable health care coverage to persons who have qualified as disabled under Title II (Disability Insurance) and is intended to provide incentives for employment for those under age 65 and promote independent community-based living by allowing those whose need for health-related care can be appropriately met in non-institutional settings to receive such services. The proposal is intended to strengthen the interaction between SSI, DI, Medicare, and Medicaid.

The ARC/PVA proposal is a departure from the present method of classifying disabled individuals as either totally entitled or totally ineligible based upon the ability to enter the labor market at some point. The proposal recognizes the

need for an integrated federalized health care support system for the disabled who are already within the federal programs. This proposal is a logical expansion of the SSI concept which placed a uniform floor of support under all low income disabled persons. Specific recommendations included:

- Expanded Medicare Coverage

The ARC/PVA proposal would extend Medicare coverage to two additional groups of people not now eligible. One group are SSI disabled beneficiaries who have been disabled 29 months or more and do not have a DI entitlement. The second group are former beneficiaries under DI or SSI who meet the medical criteria or equivalent for disability and who have been disabled at least 29 months but who have had benefits suspended because earnings are "substantial."

The 29 months period is the current Medicare waiting period; 5 month wait for benefit eligibility plus 2 year waiting period for Medicare.

- Recognition Of Specific Health Care Needs Of The Disabled Under Medicare

The proposal recommended changes in home health benefits under Medicare and Medicaid as refined and expanded in the June 4, 1979 UCPA/ARC Senate statement. Additionally, coverage of impairment related drugs was suggested.

- Medicaid Options

The ARC/PVA authors anticipate savings to the states with a modified Medicare program and hope that these savings could be redirected to provide more adequate Medicaid coverage for all low income disabled persons. Anticipated Medicaid options advocated include:

(a) Full Medicaid coverage to all SSI recipients during the first 29 months after onset of disability;

(b) Medicaid coverage of premiums, deductibles, and co-insurance for those receiving the modified Medicare benefits; and

(c) Continuation of long-term in-patient services.

- Revised Definition Of Medical Indigency

Section 1903(f)(i) of the Social Security Act defines the "medically indigent" as persons whose incomes are no higher than 133% of the state's Aid To Families With Dependent Children standard. The ARC/PVA proposal recommends revising this definition to allow eligibility up to 133% of the SSI income level.

CONSIDERING A FEDERAL LONG TERM CARE PROGRAM

The U.S. Congressional Budget Office, in defining long-term care as health and social services provided to chronically disabled persons, has estimated total demand for such services to increase from 5.5 to 9.9 million persons in 1975 to 6.3 to 11.1 million persons in 1980. Of these 5.5 to 9.9 million functionally

disabled persons, only 1.9 to 2.7 million received long-term care under government programs in 1975. Of importance to UCPA affiliates is the estimate that 1.4 to 4.7 million of these persons are between the ages of 18 and 64. In 1975, federal, state, and local governments spent $5.7 to $5.8 billion on long-term care; $3.1 billion or 56% of this was federal spending and 77% of this funding was derived from Medicaid.

The CBO concluded that "perhaps the single largest factor behind the lack of adequate or appropriate long-term care for a large number of the chronically disabled is the general lack of formal alternatives to institutional care."

The CBO study assumed that there would be little, if any, long-term care benefits in any national health insurance scheme and conceptualized three alternative possible future approaches.

1) Stimulate noninstitutional services under Medicare and Medicaid.

Such a proposal would require home health benefits as a mandatory service. One of the major arguments against this proposal is that the existing federal financing mechanism, while opening up benefits for community care, would continue to promote institutional services.

2) Establish a long-term care insurance entitlement program.

This proposal envisions institutional care, sheltered living and congregate housing, and home based services. The CBO declares that "demand for long-term care services under an entitlement (insurance) program is potentially very large because the estimated need is great." Thus, satisfaction of demand, which would depend on an increase in the supply of services, would not be fulfilled.

3) Consolidate current long-term care financing sources and funnel these through a single agency responsibility for long-term care.

This proposal would consolidate long-term care benefits under Medicare and Medicaid with Title XX Social Services into a 60% federal matching grant program. States would be required to establish community centers. This option would provide an administrative focus for long-term care, establish a uniform set of services, and eliminate the divisions between health and social services now necessitated by current financing arrangements. This would not be an entitlement program so the number of people served could be limited by appropriations.

- Can We Afford And Are We Willing To Spend The Necessary Resources?

Comparison Of Existing Programs With CBO Proposals

(in billions)

	1980	1982
Potential Demand	$ 32-47	$ 42-60
Existing Federal Programs	$ 7-8	$ 9-10
Home Health Expansion	$ 8-9	$ 11-14

Entitlement Program	$ 20-23	$ 29-36
Long-Term Care Grant Program	$ 8-9	$ 11-14

Is society willing to devote $60 billion annually to ensure that all persons with substantial disabilities receive necessary and appropriate services which allows them to reside where they desire?

Section 422 of P.L. 95-478, the "Comprehensive Older Americans Act Amendments of 1978," authorized special projects to develop comprehensive, coordinated systems of community long term care for older individuals. In response Congress appropriated $10.5 million to the Health Care Financing Administration and $10 million to the Administration on Aging to implement this initiative.

Under the auspices of the Assistant Secretary for Planning and Evaluation, HEW (soon to be Health and Human Services) has launched the "National Long Term Channeling Demonstration Program" to test the extent to which a local structure is able to organize, manage, coordinate, arrange, and finance the provision of community, in-home, and institution long term care services. Thus, HEW would like to see the long-term care grant program discussed above demonstrated. The primary target group for the demonstration is the functionally impaired elderly.

INCENTIVES AND DISINCENTIVES: CHANGING EXISTING FEDERAL MATCHING RATES

A DHEW Task Force On Deinstitutionalization proposed a January 12, 1978 option to promote community-based care by changing the federal matching rates to provide incentives and disincentives for certain types of services. The proposal is based on the following assumption:

> "Medicaid (Title XIX), by virtue of open-ended funding and an average federal match of 56.8%, provides to States a strong incentive toward institutional care of the impoverished chronically ill and disabled. Historically, Medicaid was meant to pay for the care of medical indigents and, as such, cannot be faulted for the medical model that it encompasses. But more powerful than the medical model of care and treatment is its open-ended budget - an irresistable attraction for the States, service providers, and client groups alike. Thus, we have witnessed ballooning growth of the Medicaid budget, accompanied by constant pleas for increased coverage of population and services and for more flexible standards."

The option proposal attempts to limit institutional care while promoting community alternatives. Such an approach would cap the Medicaid budget, increase the Life Safety Code standard requirement, reduce the federal matching rate for institutional services, and increase the federal matching rate for community service programs, specifically for Title XX Social Services, Vocational Rehabilitation, Developmental Disabilities, and Community Mental Health Centers. The proposal utilizes federal matching rates as national policy preferences. If we are serious about deinstitutionalization, why not alter the existing federal matching formulas to promote community living?

THE FUTURE OF CONGREGATE HOUSING: HOUSING, SERVICES, OR A UNIQUE COMBINATION?

Department of Housing and Urban Development (HUD) contracts of not less than 3 years or more than 5 years (which are renewable) are established to finance congregate housing services programs by public housing agencies or Section 202 nonprofit sponsors for the elderly or nonelderly handicapped by Title IV of P.L. 95-557, the "Congregate Housing Services Act of 1978."

Congregate services programs include "personal assistance" and "nutritional meals" to eligible residents "who, with assistance, can remain independent and avoid unnecessary institutionalization." All recipient housing projects must provide "full meal service adequate to meet nutritional needs." Personal assistance may include, but is not limited to, "grooming, dressing, and other activities which maintain personal appearance and hygiene." Housekeeping and other services essential for maintaining independent living may be financed. Service plans must be developed by housing sponsors in consultation with appropriate local social service agencies to determine the most appropriate means of providing services and identifying alternative available sources of funding such services.

The legislative history behind the enactment of the congregate housing services program involves repeated debates whether this new authority duplicates existing programs, particularly the Older Americans Act and the Title XX Social Services Program.

At a Senate hearing on the bill, both HUD and HEW testified in opposition to the legislation. T.M. Jim Parham, Deputy Assistant Secretary for Human Development Services, DHEW, opposed the bill by stating:

> "...We are not sure that this particular program is the best answer, and as you know, funds for this program were not requested in the President's budget... Thus while we agree that the goal of this legislation is a laudable one, we feel we must continue to oppose legislation that may add to the proliferation of new categorical programs - particularly when there are existing authorities whose potential to respond to the need has not been exhausted..."

Lawrence B. Simons, Assistant Secretary for Housing and Federal Housing Commissioner, HUD, also opposed the bill stating:

> "We believe however that before embarking on a new program we should carefully evaluate our existing authorities and programs particularly several recent demonstration programs which deal with the issues of providing assured services as well as housing...suggest certain areas requiring further study before deciding whether to implement..."

These reservations were not shared by many senators. Senator Harrison Williams (NJ): "The congregate housing provisions of S. 3084 would forge, for the first time, the inseparable link between shelter and services that has been lacking for low income persons with functional disabilities." Senator Frank Church (ID): Existing social service programs are governed by a maze of regulations, confronted with a wide-range of competing demands, and usually funded on an annual basis. All of these factors make them unwiedly for the guaranteed provision of nutrition,

housekeeping, personal care, and other services, which, on a long-term basis, are essential..." Senator Charles Percy (IL): "We simply know that these services, for some reason or other, are not being provided."

The congregate housing services program was finally enacted because the vast majority of members of Congress agreed with the sentiments expressed by Representative Stanley Lundine (NY): "Housing sponsors cannot commandeer long-term funding of service elements from HEW programs because of differing funding and planning schedules as well as a bewildering array of legislative and regulatory requirements for the various programs."

The Congressional conferees addressed the duplication of services issue by stating:

> "Since this is a new program designed to remedy the specific problem that occurred when HEW funds for supportive services could not be effectively coordinated with congregate facilities financed through HUD, the conferees are particularly interested in whether the unique features of this program have been successful in preventing the premature institutionalization of elderly and handicapped persons or whether it merely duplicates services available through existing HEW programs."

HUD clearly does not wish to administer this "service program"; however, even though they opposed funding for the program, the elderly and disabled consistency convinced Congress to appropriate $10 million for the program in both fiscal years 1979 and 1980. The debate is not over. It will continue. Is housing the financing and provision of physical facilities or does it entail supportive services? Can HUD adapt to meet the housing needs of special populations?

HOUSING EMPHASIS: CONSTRUCTION, REHABILITATION, PURCHASE, OR LEASE?

Much of the focus on HUD programs for the disabled is on the Section 202 loan program to construct or substantially rehabilitate housing for the elderly and handicapped. Most Section 202 loans are for construction. Current incentives encourage housing sponsors to undertake more extensive remodeling/renovation activities than are necessary to meet the needs of the residents, to purchase run-down structures, or to construct from scratch. Many advocates and professionals maintain that these incentives result in housing projects which undermine the normal, integrated, and homelike atmosphere which the sponsor should be striving to achieve.

Opinion among leaders in the field is divided concerning the long range social utility of constructing specialized residential facilities for developmentally disabled individuals - even when such facilities take the form of small, home-like community residences. The types of clients requiring specially designed facilities and the extent to which bricks and mortar solutions should be used are hotly debated issues in the field. HUD incentives are to build or substantially renovate; there is a disincentive to purchase and leasing is not currently allowed.

In a February, 1979 contract report to HUD, the National Association of Housing and Redevelopment Officials recommended that HUD seek legislation that would approve the acquisition of acceptable existing housing for small group homes without requiring substantial rehabilitation. This issue will be debated during the next several years.

PROVIDING "RELATED SERVICES" UNDER EDUCATION FOR HANDICAPPED CHILDREN MANDATES

P.L. 94-142 clearly states that our nation's handicapped children are entitled to special education and related services which meet their individual needs. The Act describes "related services as developmental, corrective, and other supportive services including speech pathology and audiology, psychological services, physical and occupational therapy, recreation, medical and counselling services." The term "related services" includes school health services, social work services in schools, and parent counselling and training. Thus, there are a broad range of services which are to be provided to handicapped children under the auspicious of related services.

The August, 1979 Bureau of Education for the Handicapped semiannual report to the Congress on P.L. 94-142 reached the following conclusions on the provision of related services:

- "Schools are largely isolated from other service providers in the community."
- "The monitoring of other public agencies by the state education agency to assure compliance with P.L. 94-142 continues to be a difficult administrative responsibility."
- "Other public agencies have tended to withdraw services to handicapped children believing that the state education agency has sole responsibility for educating all handicapped children. Because of this tendency, an increased effort is needed to develop state and local interagency agreements which assure full use of federal resources for delivering special education and related services."

The provision of related services is critical to the total educational experience for handicapped children. Yet, many children are not receiving these services. In order to address this problem, the Bureau of Education for the Handicapped (BEH) has entered into a number of interagency agreements which are designed to access services to other federal programs already providing related services. These and other interagency agreements are surely intended to foster a better understanding between BEH and other federal programs and such understanding can only enhance the quality of implementation of P.L. 94-142, especially the provision for related services. To this end, UCPA feels that BEH has taken a very laudable first step in facilitating communication between a number of agencies of the federal government.

Yet, the question must be asked, how are these interagency agreements being translated at the local level? Are they having any impact on the provision of related services to handicapped children? While it may be somewhat premature to judge the true effects of these interagency agreements, a June, 1978 survey of UCPA affiliates indicated that in many instances, related services are sadly lacking.

The vagueness of pinpointing responsibility for related service financing creates a "Catch 22" situation. In April, 1979, Vanessa M. Sheehan of the law firm of Pelletreau and Pelletreau, Patchogue, New York wrote BEH stating that some pri-

vate health insurance companies have refused to pay claims for related services, such as physical and occupational therapy. In his May 21, 1979 reply, Thomas Irvin, Chief, State Policy and Administrative Review Branch, BEH, demonstrates the vagueness of responsibility:

> BEH regulations "provide that insurers are not relieved by Part B from otherwise valid obligations to pay for services to handicapped children... Further, there is nothing in the regulations which require that parents of handicapped children use their insurance benefits for related services such as physical or occupational therapy..."

If a SEA or LEA knowing a parent has private insurance coverage, refuses to finance related services, the parent has no choice but to use it. They have thus used up benefits which other family members may need. They have stimulated the need for higher premiums. And the situation promotes negotiation while children are not served.

Short term solutions to the provision of related services under P.L. 94-142 include such items as (1) full implementation of interagency agreements, (2) greater federal funds under P.L. 94-142, (3) consideration of targeting federal funds to related services, and (4) specification of who has "first dollar" responsibility and who has "last dollar" responsibility under all cooperative agreements.

Long term solutions will require statutory changes in such programs as Maternal and Child Health, Crippled Childrens Service, Headstart, and Medicaid.

THE FUTURE ROLE OF SHELTERED WORKSHOPS AND WORK ACTIVITY CENTERS

In the past five years, the federal government has issued five major studies on the sheltered work environment for severely handicapped persons. In a response to these studies, HEW's Office of the Assistant Secretary for Planning and Evaluation (ASPE) launched the Training and Employment Service Policy Analysis (TESPA) project. TESPA has emphasized the following issues:

- How should the federal government respond to the large numbers of severely handicapped persons now being served in sheltered workshops and to the expected increase over the next decade of such workshop clients?
- How should the federal government respond to the low level of wage earnings in workshops and to the continuing financial problems experienced by such workshops?
- Is it correct to assume that "the needed changes appear to be mostly regulatory or administrative rather than legislative?"
- Is it correct that implementation of P.L. 94-142 ("Education For All Handicapped Children Act") "seems to be increasing rather than diminishing the need for training and employment in community based sheltered workshops?"

- Is it correct that the initiation of the P.L. 95-602 Independent Living program "is expected to further increase the need for sheltered employment?"

- How should the federal government respond to "recent court decisions and a growing militancy on the part of handicapped individuals" which are producing demands for improvement in the quality and quantity of services?"

As part of the TESPA initiative, HEW has contracted with the JWK International Corporation to investigate the following areas:

- The desirability and feasibility of sheltered workshops operating as both service providers and employers for persons with handicaps.

- The level of wage earnings and the disincentives to employment for persons with handicaps in workshops.

- The responsibility for financing training and employment services and ancillary programs for persons with handicapping conditions. This area is significant for the role of the state rehabilitation agencies in financing sheltered workshop services is declining and being almost totally replaced by Title XX Social Services which has resulted in sporadic funding and reimbursement limitations.

- The importance of a suitable and adequate work supply for persons with handicaps employed in community sheltered workshops.

- The entitlement of individuals with handicapping conditions to education and training.

THE EXPANSION OF CIVIL RIGHTS

The passage of Title V of the "Rehabilitation Act of 1973" (P.L. 93-112) with its Section 501 federal employment, Section 502 architectural accessibility, Section 503 affirmative action, and Section 504 nondiscrimination protections followed in 1975 with the establishment of state Protection and Advocacy Systems for the developmentally disabled firmly established federal protection of the civil rights of disabled persons. However,

- The Department of Health, Education, and Welfare did not finalize its Section 504 regulations until May 4, 1977, three and one-half years after its enactment.

- In a very narrowly focused case, Southeastern College v. Davis, the Supreme Court ruled that there are limitations to accommodation responsibilities in highly specialized professional/clinical training programs. The Court further maintained that Section 504 only prohibits illegal discrimination; it does not require affirmative action obligations by federal recipients.

- In the case of Trasgeser v. Libbie Rehabilitation Center, Inc., the U.S. Court of Appeals of the Fourth Circuit held that the mere fact that the center received federal funds did not give rise to a judicial remedy for employment discrimination. The Court held that Section 504 does not provide a judicial remedy for employment discrimination unless the provision of employment is a primary objective of the recipient. Though most legal advocates in the disability field maintain that this interpretation is probably incorrect, because the Supreme Court declined to review the case, this is the interpretation currently used in the 10 federal circuits.

- The American Public Transit Association (the trade group representing the nation's urban transportation systems) has filed suit to block enforcement of the Department of Transportation Section 504 regulations which would require accessible subways, trains, and buses over the next 3 to 10 years.

- In November, 1979 the Congressional Budget Office issued a report on Urban Transportation For Handicapped Persons: Alternative Federal Approaches and declared that "Enactment of the DOT regulations would, however, serve no more than 7% of all severely disabled persons. When the cost of implementing the DOT regulations is spread over this limited number of wheelchair users and other severely disabled passengers, the plan costs approximately $38 per trip. In contrast, transit trips by the general public cost, on the average, about $0.85."

  "While the program would be very expensive - $6.8 billion over the next 30 years - relatively few handicapped persons would benefit from it. The Congress is currently considering whether to fund these changes through reductions in other transit programs or through new approaches - or whether to enact new legislation requiring DOT or HEW to modify their rules."

- The Department of Housing and Urban Development issued its proposed Section 504 regulations in April, 1978; these were uniformly criticized by the disability field and have yet to be finalized.

- The Department of Labor just issued its proposed Section 504 regulations on January 4, 1980.

Even though Section 504 is encountering numerous problems, the Congress is considering several new legislative initiatives. These bills include:

Bill Number	Bill Provisions	Bill Status
S. 446	Add handicapped persons to Title VII Civil Rights Act employment protections.	Reported from Senate Committee and awaiting Senate floor debate.

H.R. 2540/ S. 506	Add handicapped persons to Title VIII Civil Rights Act fair housing protections.	House Judiciary Committee began mark-up but has not reported the bill - Senate Subcommittee on the Constitution has completed hearings on the bill.
S. 10/ H.R. 10	Give U.S. Justice Department "standing to sue" when rights of institutionalized persons are abused.	Passed the House - reported from Senate Committee and awaiting Senate floor debate; however, a filibuster is threatened.

Each of these bills are very controversial and are generating much emotion on all sides.

1981 DEVELOPMENTAL DISABILITIES LEGISLATION

Initially enacted on October 30, 1970 by P.L. 91-517, the Developmental Disabilities Act has been substantially revised twice in the last ten years - on October 4, 1975 by P.L. 94-103 and on November 6, 1978 by P.L. 95-602. The act expires September 30, 1981 unless renewed. A number of issues have already arisen:

- The Definition Of Developmental Disability

P.L. 95-602 moved away from the categorical definition of mental retardation, cerebral palsy, epilepsy, and autism and established a functional definition based on substantial limitations in areas of major life activity.

The definition has caused many unsubstantiated claims - the program will be overwhelmed with thousands of new clients demanding service, the program no longer emphasizes cognitive deficits, the program still favors the mentally retarded, the program places too much emphasis on the physically and emotionally handicapped!

Part of the problem is that HEW has provided no real leadership in providing guidance, support, and interpretation to the states. A contract has been given to Morgan Management Systems to define the implications of the new definition but no report (other than an initial exploration) has been published. Washington rumors are circulating that Morgan will conclude by recommending the need for another study. The EMC Institute has published a numerical and functional description of the newly defined population but it has no official status and it has been criticized.

The definition will be debated for years to come. What is currently needed is federal guidance and documented state level experience.

- The Priority Service Approach

P.L. 95-602 targeted DD emplasis and funding to four priority service areas - case management services, child development services, alternative community living arrangement services, and nonvocational social-developmental services. This approach is an attempt to maintain a balance between state government flexibility and responsibility and the achievement of national goals by the Congress. The priority ser-

vice approach was advocated as a strategy to save the program in response to the failure of the state DD programs to document the impact and significance of the DD program and in recognition of expansion in education and rehabilitation programs. It also reflects the opinion that the federal DD law has as its primary purpose the achievement of national policy goals as defined by the Congress.

The states must be able to document the impact the DD program has had on the priority service areas and document if these areas continue to remain significant gaps to comprehensive service in the country. This documentation will be a large influence on whether further statutory changes are needed. Several other service areas should be considered for addition or substitution to the priority list. Currently, DD national significance projects are studying respite care, parent training services, and services to isolated homebound and poor persons in rural or remote areas.

The priority service approach has also brought questions as to whether the DD program's planning role is being undermined or transformed into a direct service role. Does the emphasis on four priority areas undermine holistic planning? And does four priority areas result in a state allocating its funds for direct service?

Planning vs service emphasis and the targeting of state funds to natural priority areas will be debated over the next several years.

- Rights Of The Developmentally Disabled

Section 111 of the DD Act, enacted in 1975 as a companion to the establishment of the Protection and Advocacy Systems, declared Congressional findings respecting the rights of persons with developmental disabilities. In the recently announced United States Court of Appeals For The Third Circuit case involving the Pennhurst State School and Hospital, Pennsylvania Department of Public Welfare, the court determined that Section 111 of the DD Act "provides the mentally retarded with a right to treatment." Since this court judgment, speculation concerning the implications for the DD program have arisen. Some maintain that this ruling will result in pressure on the Congress to give the federal DD office enforcement responsibilities to implement Section 111. Needless to say, this speculation is causing many discomfort.

- Other Issues

Other issues related to the DD Act include DD's relationship to the new Independent Living program, the role of the DD grants of national and regional significance, and the implementability of the Section 110 comprehensive state-wide evaluation requirements.

Though several issues and statutory modifications have been discussed, many currently favor no substantial revisions in statute until 1984. This will allow some stability and continuity in the program for the next several years. It will allow both administrators and citizens to devote their energies in the area of program implementation rather than in areas of becoming familiar with new statutory changes and restructuring of state programs.

CONCLUSION: PROMOTING A NORMALIZING LIFESTYLE

All of the issues discussed in this paper are attempts to allow persons with substantial handicaps to have greater freedom of choice in selecting a lifestyle they desire. As this paper is being prepared the Senate is preparing to debate a House passed bill, H.R. 3236, which would reduce benefits of future recipients of Social Security Disability Insurance. As Senator Edward Kennedy (MA) declared: "It is a very serious matter when the Congress of the United States votes to take away protection which people have considered theirs as a matter of right..." The lives of persons with disabilities have improved tremendously during the past decade, largely because of the involvement of the federal government. This very large base of services and protections are not as secure as some may believe.

Note: No bibliography is cited in this paper to save space. Almost all information contained in this paper has been previously discussed in either the monthly legislative newsletter Word From Washington or the special Word From Washington Analysis papers. Further information on any issue or specific source citation is available by writing the UCPA Washington Office.

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